CHAPTER

3 Physician-Patient Relationship

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For centuries, healers had little understanding of disease processes and lacked the technology we now know is necessary to cure many diseases. Physicians had few medications, and surgery was only a last resort. In fact, the most important tool for healing was the relationship between the physician and the patient. Interpersonal relationships have a powerful influence on both morbidity and mortality.[1] Social connectedness can aid health in both direct and indirect ways: directly regulating many biological functions, decreasing anxiety, providing avenues for obtaining new information, and fostering alternative behaviors.[2] We know little about the basic mechanisms by which interpersonal relationships, and the physician-patient relationship in particular, operate.[3] However, clinical wisdom holds that both the reality-based elements of the physician-patient relationship—in modern times referred to as the working alliance or the therapeutic alliance[4, 5]—and the fantasy-based elements of the relationship affect the patient's pain, suffering, and recovery from illness.

Historically, physicians learned to interact with their patients in ways that relieved pain and promoted health.[6] Often the physician's main tools were reassurance, providing knowledge about the patient's disease, accepting the patient's feelings of distress as normal, and maximizing the patient's hope for the future. Although these interventions, based on wisdom and intuition, are no longer the only tools available to the physician, they continue to be an important part of the physician's and particularly the psychiatrist's therapeutic armamentarium.

Such nonspecific aspects of cure are often referred to as mystical or mysterious or, in biological studies, as the placebo effect. Oddly, these effects of interpersonal relationships are both one of the prized and one of the most denigrated aspects of all of medicine. Yet as clinicians we all strive to alleviate our patients' pain and suffering and return them to health as soon as possible. Many well-designed studies show that 20% to 30% of subjects respond to the placebo condition. The problem with placebos is not whether they work but that we do not understand how they work and, therefore, we do not have control over their effects. As a physician one strives to maximize one's interpersonal healing effects and, in this way as well as with other healing tools, increase the chances for our patients' relief of pain and recovery.

The physician-patient relationship is based on specific roles and motivations. These form the core ingredients of the healing process. In its most generic form the physician-patient relationship is defined by the coming together of an expert and a help seeker to identify, understand, and solve the problems of the help seeker. The help seeker (in modern terms, the patient) is motivated by the desire and hope for assistance and relief of pain.[7] A physician requires a genuine interest in people and a desire to help.[8] Simply stated, "the secret of the care of the patient is in caring for the patient."[9] Caring about and paying attention to a patient's suffering can yield remarkable therapeutic dividends. More than one attending physician has been reminded of this when a patient deferred making a treatment decision until he or she was able to consult with "my doctor," who turned out to be a medical student.

In today's technology-driven medicine, the importance and complexity of the physician-patient interaction are often overlooked. The amount of information the medical student or resident must learn frequently takes precedence over learning the fine points of helping the patient relax sufficiently to provide a thorough history or to allow the physician to palpate a painful abdomen. Talking with patients and understanding the intricacies of the physician-patient relationship are often given little formal attention in a medical curriculum. Even so, medical students, residents, and staff physicians recognize, often with awe, the skill of the senior physician who uncovers the lost piece of history, motivates the patient who had given up hope, or is able to talk to the distressed family without increasing their sense of hopelessness or fear.

The relationship between the physician and the patient is central to the healing of many patients and perhaps particularly so for many psychiatric patients. The physician who can skillfully recognize the patient's half-hidden comment that he or she has not been taking the prescribed medication, perhaps hidden because of feelings of shame, anger, or denial, is better able to ensure long-term compliance with medication as well as to motivate the patient to stay in treatment. Regardless of the type of treatment—

medication, biofeedback, hospitalization, psychotherapy, or the rearrangement of demands and responsibilities in the patient's life—the relationship with the physician is critical to therapeutic outcome.

Clinical Vignette 1

A 20-year-old female patient suffered a painful athletic injury. She was unsure exactly how her injury had occurred, but she did recall falling on her shoulder on the tennis court while running after a sharply hit ball. She went to the physician fearing that she had damaged her collarbone. When she was informed that there was no fracture, that her pain was due to a bruised muscle and would go away with ice, heat, and aspirin, she immediately felt better. Not only was she relieved, but also her perception and experience of the pain actually changed. "It doesn't seem to hurt as much now."

Clinical Vignette 2

Somewhat different was the situation of a 30-year-old male patient who developed chronic pain after an athletic injury. The patient had to convince himself to visit the physician. He felt he was being a "baby" to complain. One week after the injury he went to his family physician, who perfunctorily prescribed a strong painkiller and offered a follow-up appointment a month later. He left feeling that he had been a nuisance. The following week was a particularly bad one for the patient. The pain was severe. But the patient stopped taking the prescribed medication, did not keep the follow-up appointment, and never returned for help. This patient continued to experience pain, unnecessarily, for years. In large part this was because no hope was provided by the physician, and therefore follow-up care, including physical therapy and alternative medications, could not be provided.

The physician-patient relationship is also a source of information for the physician. The way in which the patient relates to the physician can help the physician understand the problems the patient is experiencing in her or his interpersonal relationships. The nature of the physician-patient relationship can also provide information about relationships in the patient's childhood family, in which interpersonal patterns are first learned. With this information the physician can better understand the patient's experience, promote cooperation between the patient and those who care for her or him, and teach the patient new behavioral strategies in an empathic manner, understanding the patient's subjective perspective, that is, the patient's feelings, thoughts, and behaviors.

Clinical Vignette 3

The patient, a 45-year-old single man, was hospitalized for treatment of a bleeding ulcer. The patient had no past history of ulcers. Despite reassurance, the patient continued to feel hopeless. A psychiatric consultant was called to evaluate the patient. She found him to be needy but could not understand why he was so pessimistic. The psychiatrist recognized the importance to this patient of showing interest in him, showing concern for his condition, and spending time with him. The patient's response was noteworthy; he clearly enjoyed the psychiatrist's company but seemed unusually sad when their times together ended. The psychiatrist asked the patient if this was a correct perception and, if so, why it was the case. The patient responded that the psychiatrist reminded him of his mother. Further inquiry revealed that the patient's mother had died several years ago of colon cancer. The psychiatrist inquired about the symptoms the mother had during her terminal illness. The symptoms were similar to the patient's symptoms: bleeding in the digestive tract and gastrointestinal pain.

The psychiatrist then understood the complex process through which the patient was feeling inordinately pessimistic. Transference was evident in the patient's experience of each departure as an unconscious reminder of the loss of his mother. The patient's identification with his mother (as part of managing her death) was also the source of his unspoken expectation that he, too, was dying of colon cancer. It was the pattern of the relationship between the psychiatrist and the patient, the sadness shown whenever the psychiatrist left, that provided the information necessary to help the patient. Increasing the patient's understanding of his medical condition, specifically how it was different from his mother's, relieved his emotional pain, and he began on the road to recovery.

These clinical vignettes illustrate that the physician-patient relationship is composed of both the reality-based component (the working alliance or therapeutic alliance) and the fantasy-based component (the transference) derived from the patient's patterns of interpersonal behavior learned in childhood. Either or both of these may maximize or limit the patient's sense of reassurance, available information, feelings of comfort, and sense of hope.[10] In this way, the nonspecific curative aspects of the physician-patient relationship may be enhanced or diminished.

Formation of the Physician-Patient Relationship

Assessment and Evaluation

The physician-patient relationship develops during the assessment and evaluation of the patient. The patient observes the thoroughness and sensitivity with which the physician collects information, performs the physical examination, and explains needed tests. At each step, the physician's clarification of the treatment goals and interventions either builds up the patient's expectation of help and feelings of safety or creates increasing dis-ease for the patient.[11] Alertness to the patient's fears and misunderstandings of the evaluation process can minimize unnecessary disruptions of the relationship and provide information on the patient's previous experiences with medical care and important authority figures. These past experiences form the patient's present expectations of either help or disappointment[12] (Table 3–1).

Rapport

Early in the relationship between a psychiatrist and a patient, the patient requests help with his or her pain, uncertainty, or

Table 3–1 Mechanisms Affecting the Formation and Structure of the Physician-Patient Relationship

Assessment and evaluation process
Development of physician-patient rapport
Therapeutic or working alliance
Transference
Countertransference
Defense mechanisms
Patient's mental status

discomfort. The psychiatrist initiates the "contract" of the relationship by acknowledging the patient's pain and offering help. In this action, the psychiatrist has recognized the patient's ill health and acknowledged the need for and possibility of removing the disease or illness. In this first stage of the development of rapport, the way of relating between the physician and the patient, the physician-patient relationship has begun to organize the interactions. Through the physician's and the patient's shared recognition of the patient's pain, the basis for rapport—a comfortable pattern of working together—is established.

The psychiatrist's ability to empathize, to understand in feeling terms the patient's subjective experience, is important to the development of rapport. Empathy is particularly important in complex interpersonal behavioral problems in which the environment (family, friends, caretakers) may wish to expel the patient and the patient has, therefore, lost hope. Suicidal patients, adolescents involved in intense family conflicts, and patients in conflict with their medical caregivers can often be convinced to cooperate with the evaluation only when the psychiatrist has shown accurate empathy early in the first meeting with the patient. When the physician acknowledges the patient's pain, the patient feels less alone and inevitably more hopeful.[13] This rapport establishes a set of principles and expectations of the physician-patient interaction. On this basic building block, more elaborate goals and responsibilities of the patient can be developed.

Clinical Vignette 4

A young man sought treatment for ill-defined reasons: he was dissatisfied with his work, his social life, and his relationship with his parents. He was unable to say how he thought the psychiatrist could help him, but he knew he was experiencing emotional pain: he felt sadness, anxiety, inhibition, and loss of a lust for living. He wanted help. The psychiatrist noted the patient's tentative style and heard the patient describe his ambivalence toward his controlling and directing father. With this in mind, the psychiatrist articulated the patient's wish for help and recognized with him his confusion about what was troubling him. She suggested that through discussion they might define together what he was looking for and how she might help him. This description of the evaluation process as a joint process of discovery established a rapport based on shared work that removed the patient's fears of control and allowed the patient to feel heard, supported, and involved in the process of regaining his health.

The Therapeutic or Working Alliance

For a patient to trust and work closely with a physician it is essential that there be a reality-based relationship outside the conflicted ones for which the patient is seeking help.[14, 15] With more disturbed patients considerable skill is required for the physician to reach this reality-based part of the patient and decrease the patient's fears and expectations of attack or humiliation. Even for healthy patients, the physician must bridge the gap between the patient and the physician that is always present because of their different backgrounds and perceptions of the world. This gap is an expectable result of differences between the physician's and the patient's culture, gender, ethnic background, socioeconomic class, religion, age, or role in the physician-patient relationship. The experienced physician makes communication across the gap seem effortless, using a different "language" for each patient. The student often sees this as an art rather than as a skill to be learned.

The therapeutic alliance is extremely important in times of crisis such as suicidality, hospitalization, and aggressive behavior. But it is also the basis of agreement about appointments, fees, and treatment requirements. In psychiatric patients, this core component of the physician-patient relationship can be disturbed and require careful tending. Frequently, the psychiatrist may feel that he or she is "threading a needle" to reach and maintain the therapeutic alliance while not activating the more disturbed elements of the patient's patterns of interpersonal relating.

The therapeutic or working alliance must endure in spite of what may, at times, be intense, irrational, delusional, characterologic, or transference-based feelings of love and hate. The working alliance must outweigh or counterbalance the distorted components of the relationship. It provides a stable base for the patient and the physician when the patient's feelings or behaviors may impair reflection and cooperation. The working alliance embodies the mutual responsibilities both physician and patient have accepted to restore the patient's health. Likewise, the working alliance must be strong enough to ensure that the treatment goes forward even when both members of the dyad may doubt that it can. The alliance requires a basic trust by the patient that the physician is working in his or her best interests, despite how the patient may feel at a given moment. Patients must be taught to be partners in the healing process and to recognize that the physician is a committed partner in that process as well. The development of common goals fosters the physician and patient seeing themselves as having reciprocal responsibilities: the physician to work in a physicianly fashion to promote healing, the patient to participate actively in formulating and supporting the treatment plan, "try on" more adaptive behaviors in the chosen mode of treatment, and take responsibility for his or her actions to the extent possible.[16]

Important to the reality-based relationship with the patient is the physician's ability to recognize and acknowledge the limitations of her or his knowledge and work collaboratively with other physicians. When this happens, patients are most often appreciative, not critical, and experience a strengthening of the alliance because of the physician's commitment to finding an answer. When a patient loses confidence in the physician, it is often because of unacknowledged shortcomings in the physician's skills.

The patient may lose motivation to maintain the alliance and seek help elsewhere. Alternatively, the patient may seek no help.

Transference and Countertransference

Transference is the tendency we all have to see someone in the present as like an important figure from our past.[17] This process occurs outside our conscious awareness and is probably a basic means used by the brain to make sense of current experience by seeing the past in the present and limiting the input of new information. Transference is more common in settings that provoke anxiety and provide few cues to how to behave—conditions typical of a hospital. Transference influences the patient's behavior and can distort the physician-patient relationship, for good or ill.[18]

Although transference is a distortion of the present reality, it is usually built around a kernel of reality that can make it difficult for the inexperienced clinician to recognize rather than react to the transference. The transference can be the elaboration of an accurate observation into the "total" explanation or the major evidence of some expected harm or loss. Often the physician may recognize transference by the pressure she or he feels to respond in a particular manner to the patient—for example, always to stay longer or not abruptly leave the patient.[19]

Transference is ubiquitous. It is a part of day-to-day experience, although its operation is outside conscious awareness. Recognizing transference in the physician-patient relationship can aid the physician in understanding the patient's deeply held expectations of help, shame, injury, or abandonment that derive from childhood experiences.

Transference reactions, of course, are not confined to the patient; the physician also superimposes the past on the present. This is called countertransference, the physician's transference to the patient (Table 3–2). Countertransference usually takes one of two forms: concordant countertransference, in which one empathizes with the patient's position, or complementary countertransference, in which one empathizes with an important figure from the patient's past.[20] For example, concordant countertransference would be evident if a patient were describing an argument with his or her boss and the psychiatrist, perhaps after a disagreement with the psychiatrist's own supervisor and without having collected detailed information from the patient, felt "Oh yeah, what a terrible boss." Similarly, complementary countertransference would be evident if the same psychiatrist felt "This person (the patient) does not work very hard, no wonder the boss is dissatisfied" and felt angry at the patient as well. Paying close attention to our personal reactions, while refraining from immediate action, can inform us in an experiential manner about subtle aspects of the patient's behavior that we may overlook or not appreciate. In the preceding example, perhaps the psychiatrist, in recognizing the countertransference, would identify the patient's subtle need to fight with authority (concordant countertransference) or the patient's passive behavior that expressed hidden anger that the nurses on the ward might have noticed and responded to with feelings of anger (complementary countertransference).

Table 3–2 Types of Countertransference

Concordant countertransference	The physician experiences and empathizes with *the patient's* emotional experience and perception of reality.
Complementary countertransference	The physician experiences and empathizes with the emotional experience and perception of reality of *an important person from the patient's life.*

Countertransference occurs in all "sizes and shapes," more or less mixed with the physician's past but often greatly influencing the physician-patient relationship. The wish to save or rescue a patient is commonly experienced and indicates a need to look for countertransference responses. When a patient is seriously ill, such as with cancer, we may increasingly want to treat the patient more aggressively, with procedures that may hold little hope, create substantial pain, and perhaps even be against the patient's wishes. The physician's feelings of loss of a valued person (in the present and as a reminder of the past) or feelings of failure (loss of the physician's own power and ability) can often fuel such reactions. More subtle factors, such as the effects of being overworked, can result in unrecognized feelings of deprivation leading to unspoken wishes for a patient to quit treatment. When these feelings appear in subtle countertransference reactions, such as being late to appointments, becoming tired in an hour, or being unable to recall previous material, they can have powerful effects on the patient's wish to continue treatment.

Major developmental events in physicians' lives can also influence their perceptions of their patients. When a psychiatrist is expecting the birth of a child, she or he may be overly sensitive to or ignore the concerns of a patient worried about a significant illness in the patient's child. Similarly, a physician with a dying parent or spouse may be unable to empathize with a patient's concerns about loss of a job, feeling that it is trivial.

Clinical Vignette 5

A psychiatrist was called to evaluate an agitated older adult resident of a nursing home. After she had interviewed the energetic, sad, and anxious patient, the psychiatrist found herself unexpectedly sad, confused, and unsure about what to do. This was not a new case for the psychiatrist, who had treated many similar cases. In considering her response, her thoughts turned to her grandmother with whom she had lived when she was 8 years old and who had been displaced from her residence and moved to a nursing home in another city by well-meaning children who wanted her near them. After the move, her grandmother had become depressed and disoriented and died 3 months later. The psychiatrist recalled feeling confused at the time of her grandmother's death, wondering why she had died when she had just moved to an attractive new home. Recalling her confusion, the psychiatrist could think more clearly about her present patient and wondered if the patient might be depressed. She talked further with the nurses and found symptoms of depression in addition to the nighttime agitation. This new information altered her decision on the type of medication to begin with and the need for psychotherapy in addition to medication.

Table 3–3 Common Defense Mechanisms

Healthier Defenses	More Primitive Defenses
Sublimation	Splitting
Humor	Projection
Repression	Projective identification
Displacement	Omnipotence
Intellectualization	Devaluing
Reaction formation	Primitive idealization
Reversal	Denial
Identification with the aggressor	
Asceticism	
Altruism	
Isolation of affect	

Defense Mechanisms

All people, including patients, employ mechanisms of defense to protect themselves from the painful awareness of feelings and memories that can provoke overwhelming anxiety. Defense mechanisms are specific cognitive processes, ways of thinking, that the mind employs to avoid painful feelings.[21] They are often characteristic of a person and form a style of cognition.[22] Common defense mechanisms include projection, repression, displacement, intellectualization, humor, suppression, and altruism (Table 3–3).

Defense mechanisms may be more or less mature depending on the degree of distortion of reality and interpersonal disruption they lead to. This patterning of feelings, thoughts, and behaviors by defense mechanisms is involuntary and arises in response to perceptions of psychic danger.[23] The patient's characteristic defense mechanisms, the cognitive processes used to lower anxiety and unpleasant feelings, can greatly affect the physician-patient relationship. Defense mechanisms operate all the time; however, in times of high anxiety, such as in a hospital or during a life crisis, patients may become much less flexible in the defenses they use and may revert to using less mature defenses.

Clinical Vignette 6

A 36-year-old army first sergeant was hospitalized for the evaluation of acute paralysis of his right hand. When the results of a neurological work-up revealed no evidence of organic pathology, psychiatric consultation was obtained. The patient denied any past psychiatric history or significant alcohol or other substance abuse. He described a healthy family support system but then hesitated, saying, "You know, Doc, there's one thing I just haven't been able to talk about with anyone." He proceeded to speak of the extreme pressure he was feeling on the job, where he had found out that his boss (the company commander) was behaving unethically. The patient stated, "I feel like I'm between a rock and a hard place—if I report it, I'm being disloyal to my boss, but if I don't, I'm betraying my soldiers and the army." After further elaborating his feelings of anger and disgust toward his boss, the patient asked to terminate the interview but agreed to talk with the psychiatrist again in the morning.

Returning the next morning, the psychiatrist was greeted by the patient, who was brushing his teeth, using his right hand. "Hey, Doc, I'm good to go!" The patient then described what happened the evening before. "I was telling my wife about how I've got to get out of here and get back to work, because, after all, I'm the commander's 'right-hand' man. And you know what, Doc? My hand started to work! Get me out of here, I'm not crazy after all!" The patient then reviewed the process, aided by the psychiatrist, and was able to further his understanding of the link between his conflicted rage toward his boss and how it was expressed symbolically as an involuntary physical paralysis of his right hand. He resolved "I'm gonna do the right thing. I got to live with myself" and planned to report the commander's misconduct on return to work. He was discharged from the hospital later that day, having regained full use of his hand.

Clinical Vignette 7

A 20-year-old man came for consultation because of uncertainty about his career. He soon revealed that he felt profoundly sad, hopeless, helpless, even suicidal. He had a family history of depression. The physician and patient agreed to employ antidepressant medication aggressively. Yet over a period of several weeks the patient did not improve. When the physician asked why that might be happening, the patient revealed that he had frequently forgotten to take the prescribed medication and had forgotten to tell the physician that this was the case during two meetings. The physician explored the reasons for this, and together the physician and the patient learned that the patient felt ashamed of having been diagnosed as depressed and of having been considered to require medication. He felt he was not his own master and had experienced this as a severe blow to his self-esteem. Taking the medication was a reminder of this "flaw." Hearing himself say this and feeling the physician's empathic support, the patient recognized the irrationality of his behavior and felt relieved. In addition, the physician now understood better the intensity of the patient's feelings and changed the prescription to once-a-day dosage at bedtime to decrease the patient's sense of shame and increase compliance with the treatment.

Clinical vignettes 6 and 7 are examples of defense mechanisms (conversion and avoidance or repression) affecting the treatment relationship. In vignette 6 the conversion reaction that resulted in the paralysis expressed both the patient's anger and his conflict over what to do. In vignette 7 the physician knew that the forgetting was neither intentional nor conscious but was directed at denying the need for treatment. In these cases, recognizing the defenses was important to knowing how to relate to the patient (clinical vignette 6) and avoid a countertransference reaction of anger at the patient for lack of compliance (clinical vignette 7).

Research on the Physician-Patient Relationship

Research examining the physician-patient relationship has focused primarily on studies of psychotherapy. In general

the research confirms what clinicians have long recognized: the physician-patient relationship is central to behavioral change in nearly all treatment modalities.[24] The therapeutic alliance has been and continues to be the most studied aspect of the psychotherapy process.[25(p308)] Pioneered by Roger's[26] view of the therapeutic relationship as providing "necessary and sufficient conditions" of change, psychotherapy process-outcome studies have focused both on identifying the effects of particular components of the therapeutic alliance and on identifying the effects of the alliance on outcome.[25(p308)] Current research focuses on the patient's affective relationship to the therapist, the patient's capacity to work purposefully in therapy, the therapist's empathic ability, and the patient's and therapist's mutual agreement on the goals and tasks of therapy.[27] Horvath and Greenberg[11] developed the Working Alliance Inventory, noted for its measurement of the interaction between therapist and patient in terms of the bond and agreement on tasks and goals.[28]

Psychotherapy outcome research has used meta-analysis to attain efficient and maximally objective integrative summaries of existing studies.[29] Early studies focused on determining the extent of the benefit associated with psychotherapy in the existing literature as a whole, compared the outcomes of different treatments, and examined the impact of methodological features of studies on the reported effectiveness of treatments. Smith and colleagues[30] found an average effect size of 0.85 standard deviation unit for 475 studies comparing treated and untreated groups. This means that, after treatment, the average treated person was better off than 80% of the untreated sample.

Subsequent meta-analytic reviews of specific disorders likewise have yielded promising results. For depression, five meta-analytic reviews totaling 133 studies showed effect sizes ranging from 0.65 to 2.15 standard deviation units. For agoraphobia, three meta-analytic reviews totaling 95 studies showed effect sizes ranging from 1.2 to 2.10 units. For obsessive-compulsive disorder, two meta-analytic reviews totaling 43 studies showed effect sizes ranging from 1.34 to 1.37 units.[31(pp144–145)]

Orlinsky and colleagues[25] used meta-analysis for more than 2300 findings on process outcome from approximately 300 psychotherapy studies conducted between 1950 and 1992. They concluded that the strongest evidence supports the importance of the therapeutic alliance to outcome, with more than 1000 significant findings. The relationship of outcome to therapeutic alliance is particularly strong when the alliance is measured from the patient's perspective; for example, it is perhaps more important that the patient feels understood and valued than that the therapist thinks this is so. What therapists do, when they do it, and whether they are genuine in doing it all matter to patients, as does the level of the patient's emotional involvement in the process.[25(pp360–361)] From the perspective of the therapeutic alliance, the therapist contributes to helping the patient achieve a favorable outcome mainly through empathic, affirmative, collaborative, and self-congruent engagement with the patient.[32]

Although there are many therapies, each with its own theoretical basis and specific techniques, there is only modest evidence to suggest the superiority of one school or technique over another. Common factors, which include the therapeutic alliance, loom large as the major mediators of treatment outcome. Research on specific techniques and research on common factors, however, are not necessarily in opposition.[31(p167)] A growing number of researchers and clinicians assert that research cannot hope to separate the unique contributions of techniques and common factors to outcome. In this view, techniques are interpersonal and gain their meaning from the particular interaction of the individuals involved.[33–35] Studies are needed to investigate the change processes associated with each of the various psychotherapeutic approaches, to determine which are common to all and which are unique.[36]

Based on the existing evidence, the therapeutic alliance accounts for much, if not most, of the gains that result from therapy. This confirms the importance of the alliance for change. Further study is needed of the therapeutic alliance in treatment settings other than psychotherapy. In the interim, the data support the notion that physicians may enhance clinical outcomes by intentionally incorporating the components of the therapeutic alliance into their relationships with patients.[31(p163)]

Special Issues in the Physician-Patient Relationship

Phase of Treatment

The treatment phase, early, middle, or late (Table 3–4), affects the structure of the physician-patient relationship in terms of both the issues to be addressed and the task to be accomplished by the physician and the patient. The early stage of treatment involves developing a rapport, forming shared initial goals, and initiating the working alliance. Education of the patient is important in the success of the physician-patient relationship in this stage. In this way the patient learns what he or she can expect. In the middle stage of treatment, the physician and patient continuously refine their shared goals and various interventions are tried. While this takes place, transference and countertransference are likely to emerge. How these are recognized and managed is critical to whether the relationship continues and is therapeutic.

In the later phase of treatment, the assessment of the outcome and plans for the future are the primary focus. The physician and the patient discuss the end of their relationship in a process known as termination. Successes and disappointments associated with the treatment are reviewed. The physician must be willing to acknowledge the patient's disappointments, as well as recognize her or his own disappointments in the treatment. The therapeutic alliance is strengthened in this stage when the physician accepts expressions of the patient's disappointments, encourages such expressions when they are not forthcoming, and prepares the patient for the future. Such preparations include

Table 3–4 Key Features of Treatment Phases

Early: developing rapport, forming shared initial goals, initiating the working alliance
Middle: refining shared goal, using a variety of trial interventions
Late: assessing outcome, resolving presenting problems, planning for future

Table 3–5 Factors Affecting the Physician-Patient Relationship

Phases of treatment: early, middle, late
Treatment setting
Transition between inpatient and outpatient treatment
Managed care
Health and illness of the physician

orienting the patient as to when he or she might seek further treatment.[37] Solidifying the physician-patient relationship at the end of treatment can be critical to the patient's self-esteem and willingness to return if symptoms reappear (Table 3–5).

As a part of the termination process the physician and the patient must review what has been learned, discuss what changes have taken place in the patient and the patient's life, and acknowledge together the sadness and joy of their leave-taking. The termination involves a mourning process, even when treatment has been brief or unpleasant. Of course, when the physician-patient relationship has been rewarding and both physician and patient are satisfied with what they have accomplished, mourning is more intense and often characterized by a bittersweet sadness.

Treatment Settings

The physician-patient relationship takes place in a variety of treatment settings. These include the private office, community clinic, emergency room, inpatient psychiatric ward, and general hospital ward. Psychiatrists treating patients in a private office may find that the relative privacy of this setting enhances the early establishment of trust related to confidentiality. In addition, the psychiatrist's personality is more evident in the private office, where personal factors influencing choice of decor, room arrangement, and location play a role. However, in contrast to the hospital or community setting, the private office generally lacks other evidence of the physician's competence and humanness. In hospital and community settings, when a colleague greets the physician and the patient in the hall or the physician receives a call for a consultation by a colleague or a meeting, these events may indicate to the patient that the physician is qualified, skilled, and humane.

On the other hand, therapeutic work conducted in the community clinic, emergency room, and general hospital ward often requires the psychiatrist and patient to adapt rapidly to meeting one another, assessing the problem, establishing treatment goals, and ensuring the appropriate interventions and follow-up. The importance of protecting the patient's needs for time, predictability, and structure can run counter to the demands of a busy service and unexpected clinical and administrative requirements. The psychiatrist must stay alert to the patient's perspective. Not all interruptions can be avoided. But the patient can be informed and accommodated as much as possible, and any feelings of hurt, disappointment, or anger can be listened for by the physician and responded to empathically. At times, patients, particularly those with borderline personality disorder, may require transfer to another psychiatrist whose schedule can accommodate the patient's exquisite needs for stability.

The boundaries of confidentiality are necessarily extended in hospital and community settings to include consultation with other physicians, nursing staff, and family members.[38] Particular attention must always be given to the patient's need for and right to respect.

Regardless of the setting, patients receiving medications must be fully informed about the potential risks and benefits of and alternatives to the recommended pharmacological treatment.[39] This is an important component of maintaining the physician-patient relationship. Patients who are informed about and involved in decisions about medication respect the physician's role and interest in their welfare. Psychiatrists must also pay particular attention to the meaning a patient attaches to any prescribed medication, particularly when the time comes to alter or discontinue its use.[40]

Transition Between Inpatient and Outpatient Treatment

Many psychiatric treatments include the sheltered environment of a hospital for at least some time. The purpose of this environment is to provide the patient with a safe refuge, a moratorium during which stressors are reduced, supportive assistance is provided, and an inner equilibrium is reestablished in the mind and life of the patient. In this situation the patient is temporarily relieved of some elements of personal responsibility, at least compared with what is expected of that person in the community. This difference is reflected in the relationship between physician and patient. The change from inpatient to outpatient therapy involves the resumption of a greater degree of autonomy by the patient in the physician-patient dyad. The physician must actively encourage this separation and its hope for the future. This transition is delicate for any therapeutic pair.

So, too, is the extremely delicate situation that occurs when the patient must switch physicians for any reason. This often occurs when a patient leaves the hospital and begins outpatient work with a new therapist. Discussing with the patient the skills and abilities of the receiving physician can alleviate much anxiety and foster the new physician-patient relationship. The knowledge that the receiving physician is known and respected by the present physician is a powerful endorsement. In difficult cases in which the strength of the therapeutic alliance is critical to the stability of the patient, as is seen in some psychotic disorders and with some patients with borderline personality disorder, it may be helpful to hold a joint meeting before the transfer. At this meeting, both the new and the old physicians should be present; the patient can be scheduled for an appointment with the new physician in the same week.

Managed Care

Managed care, broadly defined as any care of patients that is not determined solely by the provider, currently focuses on the economic aspects of delivering medical care, with little attention thus far to its potential effects on the physician-patient relationship.[41] Discontinuity of care and the creation of unrealistic expectations on the part of patients have been raised as likely deleterious effects on that relationship.[42] Other issues that can affect the physician-patient relationship include the erosion of confidentiality, shrinkage of the types of reimbursable services, and diminished autonomy of the

patient and the physician in medical decision-making. With neither party in complete control of decisions, the physician-patient relationship can become increasingly adversarial and subservient to external issues such as cost, quality of life, political expediency, and social efficiency.[43]

Psychiatrists can best serve their patients by continuing to conduct thorough diagnostic assessments covering the biological, psychological, and social aspects of the patients' condition to determine the most effective plan for treatment.[44] This plan should be openly shared with the patient regardless of whether economic considerations render it infeasible. The psychiatrist and patient may then work together to make the best of what is possible, both aware of the societal and individual factors influencing their actions. For a more detailed discussion of this topic, see Chapter 4.

Health and Illness of the Physician

Psychiatrists, like all people, become ill, and the illness can affect their ability to work effectively. Reactions of denial, projection, and hopelessness, to name but a few of the possibilities, can distort the psychiatrist's vision of the patient. The psychiatrist may be blinded to the patients' suffering or see it as if it were his or her own or, worse yet, as a hopeless situation. In some instances, a physician who is ill must leave a practice, temporarily or permanently, and in that situation therapy enters a late phase in which termination must take place. In some cases, when the onset of illness is devastating, this can be impossible; in other cases termination may have to be rapid. Sometimes, such as when the physician dies suddenly, colleagues must step in to conduct the termination of therapy or the patient's transfer and transition to another physician.[45, 46]

Depression and grief can also impair the physician's ability to make use of accurate empathy and medical decision-making. It is important for physicians to stay alert to these influences and seek clinical supervision or consultation to ensure accurate decision-making and a consistent physician-patient relationship. A thoughtful colleague who recognizes the role of depression and grief in the life course can both assist in any treatment that is needed and help to provide a necessary period of clinical supervision or consultation.

The Physician-Patient Relationship in Specific Populations of Patients

Cross-Cultural and Ethnic Issues

Addressing cross-cultural issues such as race, ethnicity, religion, and gender is vital to the establishment and maintenance of an effective physician-patient relationship. Psychiatry as practiced in the United States generally represents the value orientation of the American middle-class family, emphasizing individualism, scientific rationale, free expression of speech, and tolerance of dissent.[47] Accordingly, therapists may unconsciously make value judgments stemming from their personal cultural perspective, without adequate appreciation for the diversity of normal behavior.[3] For example, assertiveness may be seen as manipulativeness, stoicism as passivity, religious ritual as compulsion, competence as dominance, unselfishness as masochism, charm as seductiveness, lack of concern with appearance as depression, family orientation as dependency, and homosexuality as perversion. Even similarities in background may create misunderstanding, in that both physician and patient may make unjustified assumptions or fail to explore certain behaviors or symptoms because the reasons for them seem self-evident. Failure to clarify cultural assumptions, whether stemming from differences or similarities in background, may impede the establishment of a trusting therapeutic alliance, making effective treatment unlikely.[48]

Every individual is inevitably like everyone else, like someone else, and like no one else.[49] Thus, every physician-patient relationship involves the universal, the group-specific, and the unique aspects of each participant.[50] Maintaining a thoughtful awareness of and appreciation for the influence of cross-cultural issues can enrich and empower the physician-patient relationship.

When psychiatrists work with a patient who belongs to or identifies with a particular ethnic or minority group, they are well advised to learn about the culture of the patient and use caution in making assumptions based on stereotypical or popular beliefs. This is true even when the psychiatrist has the same ethnic or minority group background. Other significant cross-cultural factors include gender, sexual orientation, physical appearance, religious background, and personal experience.[51]

Ethnicity, culture, and race can stir deep unconscious feelings in many individuals that may surface as projections within the physician-patient relationship. The physician must strive to understand what it is like to live in the patient's world, however divergent its patterns or values may be from those of the physician's world. Maintaining therapeutic neutrality may be difficult and, in some cases, require the physician to seek further consultation.[52]

Children, Adolescents, and Families

Establishing an effective physician-patient relationship with children, adolescents, and families is one of the most challenging and rewarding tasks in the practice of psychiatry. Rather than being treated as "little adults," children and adolescents must be approached with an appreciation for their age-appropriate developmental tasks and needs. When physicians treat this population, they must establish a trusting relationship with both the patient and the parents. Preadolescent children face the psychosocial developmental tasks of establishing trust, autonomy, initiative, and achievement. By understanding the facets of normal childhood development, physicians may help parents understand the nature of their child's disturbance and work within the family system to manage effective mechanisms for coping and recovery.[53, 54]

Adolescent patients, facing the task of establishing an individual identity, pose particular challenges to the physician-patient relationship. Adolescents are particularly sensitive to any signals from the physician that their powers of decision, their intelligence, or their perceptions are being ignored. The critical time for engagement with the adolescent is often in the first session, sometimes even in the first few minutes.[55] Defiance, detachment, and aggression may be anticipated and defused with a steady therapeutic presence grounded in consistent boundaries and open acknowledgment of the adolescent patient's distress.[56]

In working with families, physicians in general and psychiatrists in particular must clearly address questions and concerns regarding all aspects of treatment and convey respectful compassion for all members. The therapeutic alliance, or "joining" with the family and patient, requires developing enough of a family consensus that treatment is worth the struggle involved. Taking sides and engaging with individual and family power struggles can be particularly destructive to the physician-patient relationship in families. Rather, it is the physician's ability to relate to the family as a multifaceted organism, massively interconnected, transcending the sum of its parts, that often allows treatment to progress and, in the best scenarios, for growth and understanding to occur.[57, 58]

Terminally Ill Patients

Terminally ill patients share concerns related to the end of the life cycle. Elderly patients at all levels of health face the developmental task of integrating the various threads of their life into a figurative tapestry that reflects their lifelong feelings, thoughts, values, goals, beliefs, experiences, and relationships and places them into a meaningful perspective. Patients newly diagnosed with a terminal illness such as metastatic cancer or acquired immunodeficiency syndrome may be particularly overwhelmed and initially unable to deal with the demands of their illness, especially if the patient is a younger adult or child. Psychiatrists may enhance the terminally ill patient's ability to cope by addressing issues related to medical treatment, pharmacotherapy, psychotherapy, involvement of significant others, legal matters, and institutional care.[59(pp275–276)] Patients struggling with spiritual or religious concerns may benefit from a religious consultation, a resource that is frequently unused.

Countertransference feelings ranging from fear to helplessness to rage to despair can assist the therapist greatly in maintaining the physician-patient relationship and ensuring appropriate care. Physicians working with patients with acquired immunodeficiency syndrome must frequently confront their own feelings and attitudes toward homosexuality.[60] Issues commonly encountered with disabled patients include inaccurate assumptions about their ability to function fully in all areas of human activity, including sex and vocation. Terminally ill patients may evoke reactions of unwarranted pessimism, thwarting the physician's ability to help the patient maximize hope for the quality of whatever time may remain. Patients and their family members often look to their physician for guidance.

Physicians, Important Persons, and Relatives

Treating other physicians, important persons, and personal relatives poses significant risks that must be actively addressed within the physician-patient relationship. Patients who are physicians are frequently expected to assume greater responsibility for their care and, if there is evidence of poor compliance, to "know better." Relinquishing control and acknowledging dependency run counter to the professional development of most physicians, who are accustomed to caring for others and may fear becoming a burden. Furthermore, they may refrain from asking pertinent questions to avoid further embarrassment and humiliation.[59(p4)]

Patients who are important persons or personal relatives pose similar challenges. With these patients and with other physicians, the treating physician may feel insecure and under increased pressure to perform flawlessly. Psychiatrists risk losing their usual assessment benchmarks when making exceptions to standard practice habits in recognition of a patient's special status. Difficult transferential issues for the physician include managing self-esteem, overidentification with the patient, ethical boundaries, and the potential dilemmas arising from ruptured treatment. Professional identification, awe of celebrity, and personal attachment exert tremendous pressures that can tax even the most seasoned psychiatrist in maintaining a healthy relationship with the patient. The psychiatrist may consult with uninvolved peers and, especially in the case of patients who are relatives, arrange for timely referrals to ensure appropriate treatment.[61]

Conclusion

The physician-patient relationship is essential to the healing process and is the foundation on which an effective treatment plan may be negotiated, integrating the best of what medical technology and human caring can provide. The centrality of this relationship is particularly true for psychiatric physicians and their patients. In the psychiatrist-patient relationship, empathy, compassion, and hope frequently serve as major means of alleviating pain and enhancing active participation in all treatment interventions: biological, psychological, and social.

The development of the physician-patient relationship depends on skilled assessment, the development of rapport through empathy, a strong therapeutic alliance, and the effective understanding of transference, countertransference, and defense mechanisms. Current research findings support the purposeful use of common therapy factors, of which the therapeutic alliance is the most powerful, to enhance clinical outcome.

The development of the physician-patient relationship is influenced by numerous factors, including the phase of treatment, the treatment setting, transitions between inpatient and outpatient care, managed care, and changes in the physician's health. The astute physician is attuned to the needs and characteristics of specific populations of patients, adopting the therapeutic approach that most effectively bridges the gap between physician and patient and leads to a healing relationship.

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CHAPTER

4 Professional Ethics and Boundaries of the Clinical Relationship

Richard S. Epstein

In the past several decades, advances in psychiatry have made it possible to treat mental disorders that were previously not amenable to successful intervention. There has been a dark side to this progress, however, because futuristic anticipation of subduing disease and forcing nature to surrender its secrets has led many practitioners to outrun their headlights. Like technical sorcerers of science fiction confusing promise with reality, we are in danger of being lulled into an intellectual arrogance that can cause us to forget what it means to be professionals. One manifestation of this process has been the defensive reliance by clinicians on reductionistic explanations for complex and multidetermined disorders, combined with a neglect of the important role of trust and empathy as curative factors in treating mental disorders.

A bewildering potpourri of treatment options and methods for financing health care presents psychiatrists with other sources of confusion. Patients' health and safety often depend on our ability to decide whether they require outpatient or inpatient treatment, brief psychotherapy, or long-term care. The psychiatrist's dilemma is similarly compounded by conflicts between the cost-determined restrictions of managed care and the sacred promise to advocate primarily for patients' welfare.

Building a cooperative and trusting relationship with patients has always been an essential factor enabling clinicians to foster the healing process, especially during ancient times, when few specific remedies were available. In most instances, modern technology augments but cannot substitute for a trusting physician-patient relationship. Patients seeking medical care must suspend ordinary social distance and critical judgment if they are to allow physicians to enter their physical and psychological space. Although neither the law nor medical ethics relieve patients from taking an active responsibility for treatment outcome,[1] society places a greater burden on the healer—a mandate to act with the special care and vigilance expected of a fiduciary[2, 3] or of a common carrier,[4(pp59–61)] as a precondition for granting licenses to practice.

As I review in this chapter, the ability to sustain a professional attitude and to practice within a set of coherent boundaries forms the foundation of proper psychiatric treatment, regardless of theoretical orientation or treatment modality. An understanding of psychiatric ethics plays a vital role in the psychiatrist's ability to keep proper boundaries, because these values provide a stable beacon in the cognitively perplexing fog that so often pervades the treatment situation.

Ethical Behavior and Its Relationship to the Professional Attitude

The term *professional* derives from medieval times, when scholastics were expected to "profess" their belief in a doctrine.[5(p17)] In modern times, a professional is assumed to be a learned person who has acquired special knowledge of a subject that is of vital importance for the welfare of the community. Having expertise is not enough, however. A professional is also obliged to adhere to certain societal responsibilities that are founded on a code of ethical behavior and an attitude of service to those in need. A professional commitment to ethical behavior and service must take precedence over monetary compensation.[5(p16)] All physicians, including psychiatrists, are bound by such a covenant—a sacred vow to place the patient's well-being before other considerations.[6] In Western medical tradition, this obligation derives from the teachings of Hippocrates in the fifth century BC. The oath of Hippocrates is the pledge predominantly recited at the graduation exercises at American medical schools,[7] and it contains three of the six core principles of modern medical ethics: *beneficence, nonmalfeasance,* and *confidentiality:*

> I will follow that system of regimen which according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous . . . . With purity and holiness I will pass my life and practice my Art . . . . Into whatever houses I enter,

Table 4–1 Six Basic Principles of Medical Ethics

Principle	Description
Beneficence	Applying one's abilities solely for the patient's well-being
Nonmalfeasance	Avoiding harm to a patient
Autonomy	Respect for a patient's independence
Justice	Avoiding prejudicial bias based on idiosyncrasies of the patient's background, behavior, or station in life
Confidentiality	Respect for the patient's privacy
Veracity	Truthfulness with oneself and one's patients

Adapted from Epstein RS: Keeping Boundaries. Maintaining Safety and Integrity in the Psychotherapeutic Process. Washington, DC: American Psychiatric Press, 1994:20.

> I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.[8]

The other three general principles of medical ethics are *autonomy*, *justice*, and *veracity* (see Table 4–1 for a description and summary of all six ethical principles).[4(p20)] In 1973 the American Psychiatric Association adopted the American Medical Association's principles of medical ethics, publishing them along with special annotations applicable for psychiatric practice.[9] The American Psychiatric Association has produced six revisions of these annotations.[10] The seven sections of the American Medical Association principles are summarized in Table 4–2. Table 4–3 summarizes some of the more salient ethical annotations for psychiatrists.[10]

The Coherent Treatment Frame and the Role of Therapeutic Boundaries in Effective Psychiatric Treatment

The *frame* of a social interaction was defined by Goffman[11] as consisting of the spoken and unspoken expectations defining meaning and involvement in a given situation. For example, patients seek out a psychiatrist on the basis of a tacit assumption that the psychiatrist is a reliable and experienced clinician who has the ability to assist them in finding relief for distress. However, many patients tend to frame their treatment in pathological ways. For example, some attempt to pressure the psychiatrist into the role of a magical wizard who confers unconditional love and pleasure. Whatever method the patient employs to frame the relationship, any abrupt disappointment or rupture of these unspoken expectations often results in intense and disruptive feelings of mortification and betrayal. A sudden breach of a social frame can lead to the dissolution of one's sense of meaning and connection and is often accompanied by intense feelings of shame. By examining verbal and behavioral responses after violations of the treatment frame, Langs[12] was able to document that patients usually perceive the offending therapist as an unreliable and mentally unstable person—someone seeking perverse pleasure at another person's expense.

The psychiatrist's task is to provide a coherent therapeutic frame within which to contain the patient's illness. The psychiatrist's frame makes it secure to proceed with the specific therapeutic modality, just as the surgical suite provides a safe environment for operative techniques.

Table 4–2 Summary of the Principles of Ethics of the American Medical Association

Section	Statement of Principle
Preamble	The medical profession's ethical standards are designed primarily for the well-being of patients. As professionals, physicians are required to acknowledge a responsibility to patients, to society, to self, and to their colleagues.
Section I	Dedication to competent, compassionate care. Respect for human dignity.
Section II	Obligation to deal honestly with patients and colleagues and to expose physicians who are incompetent or fraudulent.
Section III	Respect for the law. Obligation to seek changes in laws harmful to patients' care.
Section IV	Respect for the rights of patients and colleagues. Within legal constraints, preservation of confidentiality.
Section V	Commitment to continued education, sharing of relevant knowledge, and obtaining necessary consultation.
Section VI	Except in emergency, freedom to decide whom to treat, with whom to associate, and the setting in which one serves.
Section VII	Acknowledge the responsibility to contribute to improving the community.

From American Psychiatric Association: The Principles of Medical Ethics. With Annotations Especially Applicable to Psychiatry. Washington, DC: American Psychiatric Association, 1993.

Table 4–3 Summary of Selected Ethical Principles for Psychiatrists

Principle	Annotations
Competent care	The psychiatrist must scrutinize the effect of his or her conduct on the boundaries of the treatment relationship.
Honest dealing	Sex with a current or former patient is unethical. Information given by patients should not be exploited. Contractual arrangements should be explicit. Fee splitting is unethical.
Confidentiality, respecting colleagues	Restraint in release of information to third parties. Adequate disguise of case presentations. Disclosure of lack of confidentiality in nontreatment situations. Sex with students or supervisees may be unethical.

From American Psychiatric Association: The Principles of Medical Ethics. With Annotations Especially Applicable to Psychiatry. Washington, DC: American Psychiatric Association, 1993.

Table 4–4 Factors Common to All Successful Psychotherapy

Principle	Method Applied
Inspiring trust	The therapist establishes an emotionally arousing, trusting, and confidential relationship.
Coherent structure	A structured setting is formed that is associated with the healing process.
Rationale explained	A reasoned treatment method is offered that plausibly explains the patient's problems.
Cooperative engagement	Therapist and patient actively work together in the program. Both believe that it will work.

From Frank JD, Frank JB: Persuasion and Healing. A Comparative Study of Psychotherapy, 3rd ed. Baltimore: The Johns Hopkins University Press, 1991. Reprinted by permission of Johns Hopkins University Press.

The treatment frame enables the patient to maintain a feeling of trust and connectedness while learning to deal with the unrealistic nature of his or her expectations. The frame comprises various boundary factors, including acting in a reliable way, showing respect for the patient's autonomy by explaining the potential risks and benefits of the treatment method, maintaining confidentiality, avoiding exploitation of the patient's sexual feelings, and resisting the patient's manipulative efforts by explaining the maladaptive nature of such behavior.[4, 13]

Frank and Frank[2] conducted an extensive review of the literature concerning psychotherapy outcome. They determined that four basic factors were common to all successful psychotherapies (Table 4–4) and that treatment efficacy relied on the ability of the therapist to form a structured, mutually trusting, confidential, and emotionally arousing relationship. Their findings sustain the argument that maintaining a coherent treatment frame is an essential part of all psychiatric treatment, regardless of the therapeutic paradigm being employed. These issues are important whether the patient is being treated solely with psychotropic medication management, behavior therapy, or psychoanalysis.

Boundary Violations

Psychiatric treatment cannot be conducted without psychiatrist and patient entering into each other's space, just as it is impossible to perform a bloodless laparotomy. Gutheil and Gabbard[14] termed such incursions that occur during the therapeutic process *boundary crossings*. They defined boundary *violations* as boundary crossings that cause injury to the patient. However, it is not always easy to be sure of the consequences of such a crossing, because harmful effects may be delayed or concealed. Many patients are unable to articulate their sense of injury, because the psychiatrist's aberrant behavior may appear so similar to exploitation they have experienced in previous pathological relationships. For example, patients who were sexually abused in childhood are more likely to acquiesce to an amorous advance by a psychiatrist and to avoid complaining about feeling used, because they fear the threat of the psychiatrist's rejection and retaliation. Certain nonsexual boundary crossings, such as conflicts of interest, might seem harmless on the surface but can interfere with patients' ability to feel safe in their psychiatrist's care and diminish their chances for optimal recovery. In this context, a boundary violation can be defined as any infringement that interferes with the primary goal of providing care or causes harm to the patient, the therapist, or the therapy itself.[4(p2)]

Before the 1970s, open discussion of the topic of sexual involvement between psychiatrists and patients was virtually taboo and considered "too hot to handle" as a subject for publication in scientific journals.[15] Professional societies demonstrated an inconsistent and confused attitude of "amused tolerance"[16(p161)] toward mental health practitioners who engaged in sexual behavior with their patients.

In the past 20 years, the public has become increasingly interested in the subject of psychiatric boundary violations, particularly those involving sexual exploitation. State licensing boards, professional ethics committees, and civil juries are much more likely than ever before to mete out strong sanctions against violators. These attitudinal changes have taken place in spite of the fact that Hollywood movies continue to romanticize the idea of psychiatrist-patient sexuality and almost always seem oblivious to the horrendous feelings of shame, betrayal, and devastation that patients experience when these things happen to them in real life.

The public's intolerance of sexual involvement between psychiatrists and patients has resulted in part from the increasing empowerment of the victims of incest, rape, and spousal abuse and a better understanding of the psychological sequelae of mental trauma, such as posttraumatic stress disorder. In addition, psychiatric patients have become more willing to expose unethical or exploitative behavior on the part of clinicians, particularly when it involves sexual activity. This trend has been augmented by the fact that courts and professional licensing bodies are now more inclined to render sanctions for injuries that are solely psychological in nature.

Quantitative estimates of the frequency of sexual boundary violations among mental health professionals derive from survey studies conducted during the past 20 years.[16–22] A review of these studies shows that from 5.5% to 13.7% of male mental health clinicians admitted to engaging in sexual activity with patients. Epstein[4(pp207–208)] calculated a crude weighted average from Schoener's[22] comprehensive review of survey studies reporting frequency of sexual violations by clinicians' gender. From 10 studies involving a total of 5816 respondents (excluding a large survey of nurses), an average of 7.4% of male and 2.3% of female clinicians admitted to engaging in sexual behavior with patients. These data suggest that male clinicians are about three times more likely to admit they have become sexually involved with patients. Although subsequent studies suggested that sexual exploitation by mental health practitioners might be occurring less frequently, increasing reports in the media of severe sanctions taken against offending therapists have probably diminished the value of self-report questionnaires.

Studies of nonsexual violations suggested that many mental health clinicians still have serious problems maintaining professional boundaries with patients.[21, 23] Epstein and colleagues[23] queried 532 psychiatrists about their behavior with patients within a prior 2-year period. They

found that 19% of respondents reported engaging in a personal relationship with patients after treatment was terminated, 17% told patients personal details of their life to impress the patients, and 17% joined in activities with patients to deceive a third party such as an insurance company (Table 4–5). Simon[24] emphasized that when clinicians engage in nonsexual infringements of the treatment relationship, it is often a prelude to subsequent sexual behavior. Sexual involvement with patients often starts with excessive personal disclosure, accepting and giving gifts, requesting favors, and meeting patients outside the office setting. Like a seduction, the behavior escalates over time until it culminates in sexual contact.[24]

Regardless of the specific type of infringement involved, there are common elements to all boundary violations. Peterson[25] argued that such activity emanated from a disturbed and disconnected relationship. She suggested four basic behavioral themes in this regard: efforts on the part of the clinician to reverse roles with the patient, to intimidate the patient to maintain secrecy, to place the patient in a double bind, and to indulge professional privilege.[25] Indulgence of privilege is often accompanied by a sense of entitlement on the clinician's part, such that she or he regards the patient as a wholly owned subsidiary.

Epstein[4(pp89–110)] outlined the progression of boundary violations as they originate from dysregulation in the clinician's personal ego boundaries. Circumstances impairing the clinician's ability to cope with patients and their problems may include deficient knowledge, general stress, mental disorder, or a treatment-induced regression. These factors may lead the clinician to employ maladaptive intrapsychic or behavioral coping mechanisms that are manifest in the form of therapeutic boundary violations. Other general factors common to all boundary violations include a slippage of the original purpose of the treatment,[4(pp97–98)] pseudoeclecticism,[26] a narcissistic sense of specialness,[4(pp107–110), 27] and efforts to deprofessionalize the relationship by fostering an atmosphere of "pseudoequality" between clinician and patient.[25]

The double-binding messages that exploitative clinicians employ often represent a way for them to project their own disavowed feelings of shame and inadequacy onto vulnerable patients. For example, a therapist may deceive a patient suffering from low self-esteem and sexual dysfunction by encouraging a sexual relationship between them. The therapist may rationalize:

> You have told me that you feel unattractive and inadequate. Because therapy is supposed to help you with your problems, I will help show you how attractive and effective you are by having sex with you.

Psychotherapy and erotic behavior can both be construed as subcategories of the superordinate class of "activities that help people feel better."[4(p102)] In the preceding example, the exploitative therapist blurs the logical boundaries between the two subcategories and fails to inform the patient that this sexual behavior is likely to be harmful to the patient. Blurring of logical categories is an essential aspect of double-binding messages. Patients who are subjected to such reasoning are often in a dependent and cognitively regressed state and are unable to understand the logical absurdity of the double bind. They fear that if they refuse to comply with the therapist's suggestions, they will be rejected for failing to cooperate with the goals of therapy.

It is important to place the burgeoning literature on boundary violations in its social context. An aroused public has been exposed to recurring reports of psychiatrists and other mental health professionals who have been disciplined or sued for behavior such as sexual involvement with patients and spouses of patients, using information learned in patients' psychotherapy sessions to gain inside data on financial investments, and accepting large bequests from elderly patients. Each new scandal serves to erode society's trust in the integrity of psychiatry as a profession and makes it more difficult for the mentally ill to obtain needed treatment. Compounding this problem is the fact that many of these well-publicized reports of boundary violations involved highly trained psychiatrists who were leaders in their field and who served as important role models for students in professional training.

As has occurred many times before in history, societal changes tend to overshoot the mark, leading some observers to caution against a hysterical witch-hunt against suspected offenders. Slovenko[28] cautioned that the climate has become ripe for an increasing number of false accusations to be made against innocent clinicians. Gutheil[29] has documented such cases and provided guidelines for proper forensic psychiatric evaluation after allegations of sexual misconduct.

Table 4–5 Summary of Survey Results of Nonsexual Boundary Violations Among 532 Psychiatrists

Behavior	Percentage
Using touch (exclusive of handshake)	45
Treating relatives or friends	32
Personal relationships after termination	19
Personal disclosure	17
Colluding with patient against third party	17
Influencing patient for political causes	10
Using patient's communication for financial gain	7

From Epstein RS, Simon RI, Kay GG: Assessing boundary violations in psychotherapy: Survey results with the Exploitation Index. Bull Menninger Clin 1992; 56:150–166.

Components of the Coherent Psychiatric Frame

The purpose of the therapeutic frame is to protect the patient's safety and to promote recovery. It is the therapist's responsibility to structure the frame through word and deed. Langs[12] stressed that a healthy and secure therapeutic environment is predicated on reducing variability and uncertainty in the treatment setting as much as possible. Table 4–6 summarizes the major boundary factors of the coherent treatment frame. Careful attention to these boundary issues can help treating psychiatrists to communicate defining messages that strengthen the differentiation of role and identity between patient and practitioner.

There is an enormous diversity of opinion regarding the diagnosis and treatment of psychiatric disorders. This makes it difficult to devise a set of specific guidelines that are

Table 4–6 Major Boundary Issues Contributing to the Formation of a Coherent Treatment Frame

Boundary Issue	Function and Purpose	Implicit Message to Patient
Stability	Consistency as to time, place, location, parties involved, and treatment method	"The doctor is reliable. This treatment can contain my irrationality."
Avoiding dual relationships	Utmost fidelity to the primary purpose of helping the patient	"The doctor focuses her or his attention on my problem and is not sidetracked."
Neutrality and promoting autonomy of the patient	Avoiding abuse of power and promoting the patient's independence	"The doctor values my ideas and encourages me to exercise choices."
Noncollusive compensation	Scrupulous and forthright terms of remuneration for the clinician	"Aside from the payment, I don't have to gratify the doctor."
Confidentiality	To protect the patient's privilege of keeping his or her communications secret	"My thoughts and feelings belong to me, not to the doctor."
Anonymity	Avoids seductiveness and role reversal	"This is a place to bring *my* issues, not a forum for the doctor's personal problems."
Abstinence	Encourages verbalization rather than action in dealing with feelings and conflicts	"There is a big difference between wishes and reality."
Preserving the clinician's safety and self-respect	Discourages the patient's destructive behavior, sets a good role model for establishing healthy self-esteem	"It is possible to have a close relationship without someone getting hurt."

appropriate for psychiatrists adhering to a wide spectrum of theoretical orientations. Dyer[5(pp45–57)] emphasized how problematic it is to define a comprehensive ethical system, whether it is based on a set of specific rules (deontological ethics), on a list of values and goals (teleological ethics), or on consideration of the emotional and practical consequences of a given course of action (consequentialist ethics). A parallel dilemma exists when it comes to defining psychiatric boundaries. For this reason, guidelines for psychiatrists should enhance patients' safety, foster adherence to established clinical principles, and help to avoid specific consequences that are detrimental to either patient or practitioner. From a safety standpoint, each boundary issue can be examined from the point of view of clearly *indicated* procedures, *relatively risky* procedures, and *contraindicated* procedures.[4(pp113–117)] In the ensuing discussion of components of the psychiatric frame, lists of these various types of procedures are adapted from my earlier work on boundaries.[4(pp119–236)]

Riskier procedures that fall into the gray zone are not necessarily unethical or unsound. However, psychiatrists who engage in such activity should be aware of the circumstances under which they increase or reduce the chance for injury to either the patient or themselves. For example, under most conditions, it is probably unwise to attempt psychiatric treatment of one's next-door neighbor. Nevertheless, practitioners living in remote areas or working in confined ethnic communities might, as a matter of practicality, be forced to treat a patient for whom no reasonable alternative exists. The hazard of no treatment may outweigh other factors in this situation. However, the fact that psychiatrists sometimes must treat patients under risky circumstances does not mean they should forget about the highest treatment standards, just as the exigencies of battlefield surgery do not obviate the need to remember aseptic technique.

Psychiatrists should safeguard against any semblance of inappropriate behavior, even if the activity can be justified as harmless. For example, seeking social activities with patients outside the treatment setting can be interpreted by patients or their family members as seductive. Gutheil and Gabbard[14] have emphasized that the very appearance of undue familiarity with a patient may in and of itself hamper successful defense against false allegations of professional wrongdoing.

Stability

A stable and consistent treatment setting is analogous to the "holding environment" provided by parents in early childhood.[30] Patients with psychiatric illnesses find it difficult to entrust their lives to a psychiatrist whom they perceive to be unreliable. Indicated measures regarding stability include formulating an agreement with the patient for a treatment regimen to take place according to a specific method and schedule, encouraging truthful disclosure and cooperation, establishing a commitment to beginning and ending sessions on time, discouraging interruptions during treatment sessions, offering advance notice about when the psychiatrist will be absent, providing for coverage by another practitioner when the psychiatrist is off duty, maintaining coherent therapeutic demeanor, and maintaining relative consistency as to who participates in the treatment situation.

It is generally unwise for a psychiatrist to disparage a patient's complaints about issues like the psychiatrist's tardiness in starting sessions or to become defensive when explaining the meaning of the patient's distress about such complaints. Many psychiatrists experience patients' demands for consistency as a form of control and imprisonment. Out of anger, they may react to these patients as if their wishes for reliability and concern were infantile and irrational:

> Your complaints about my lateness are a reflection of your need to control me.

The psychiatrist's tardiness might in fact be creating tremendous anxiety because it reminds the patients of parents who never took their feelings into account.

Avoiding Dual Relationships

Psychiatrists should avoid treatment situations that place them in a conflict between therapeutic responsibility to patients and third parties. Examples of dual relationships in psychiatric practice include clinicians treating their own relatives and friends, the same therapist employing concurrent family and individual therapy paradigms with a patient, and clinicians testifying as forensic witnesses for current psychotherapy patients. Although it is common practice,[23] accepting psychotherapy patients referred by one's current or former patients embraces certain risks that must be considered.[32(pp60–62)] For example, a current patient might refer an attractive friend for therapy as a way of either seducing the therapist or sabotaging the treatment.[31(pp60–62)]

Role conflicts are quite widespread[32] and interfere with the practitioner's single-mindedness of purpose as a healer. Chodoff[33(pp457–459)] placed special emphasis on this issue by arguing that advocating for the needs of the mentally ill was one of psychiatry's primary societal responsibilities. By eroding public trust, dual relationships interfere with the ability of psychiatrists to carry out their vital functions in the community.

The burgeoning expansion of prepaid care in the United States in the past two decades has provoked concern about a new source of role conflict for psychiatrists. Managed care has been espoused as an important modality for reducing unnecessary treatment by encouraging preventive care and promoting cost-consciousness among physicians.[34] Stephen Appelbaum[35] argued that psychotherapists practicing under the old fee-for-service model were more inclined to provide unnecessarily prolonged treatment than those working under an organizational system that prevented direct monetary involvement between patient and practitioner.

On the other hand, increasing coverage of the population of the United States under a system of managed care has generated serious concerns regarding potential conflicts of interest.[36(pp113–126)] This disquietude is particularly noticeable in the field of psychiatry. Many managed care organizations have severely restricted the number of psychiatrists within a given community allowed to serve on their treatment panels. Patients' access to their regular treating practitioner have been further limited, even when the practitioner is allowed to enroll on the panel. For example, under the rules of some managed care organizations, a psychiatrist might be prevented from maintaining continuity of care for outpatients needing hospitalization. During their hospital stay, such patients must be attended by a preselected group of psychiatrists who conduct all hospital treatment for the plan.

Despite the contention that restricted managed care panels are necessary for lowering costs, it is important that both patients and clinicians be informed about the hazard such a system of care entails. Because participation on a panel is often contingent on cost-efficiency profiles, psychiatrists who derive a significant portion of their income from a given managed care organization are discouraged from advocating for patients needing more expensive care. With news reports of physicians claiming they were terminated from managed care contracts because they protested treatment denials, fear of retaliation for advocacy for patients has mounted.[37] Retired judge Marvin Atlas[38] has suggested that psychiatrists who fail to warn patients about the risks of their role conflicts would be exposing themselves to civil damages in the event of an adverse outcome. Although the extent of the legal duty to disclose risk factors under managed care is unresolved, Paul Appelbaum[39] proposed that mental health clinicians inform beginning patients that payment for treatment under managed care might be stopped before the patient feels ready to terminate.

Limitations on who may serve on a managed care panel and what functions the clinician may perform are other factors that have strong potential for creating disruption in the continuity of care. For example, Westermeyer[40] described seven case histories in which psychiatric patients treated under managed care committed suicide or suffered serious clinical deterioration. Clinically uninformed managed care practices appeared to serve as critical aggravating factors for each of these patients. In the cases of two individuals who committed suicide, the employer had switched contracts to different managed care companies and the patients were forced to transfer to new clinicians. These disruptions appeared to play an important role in the patients' suicides.

Although more research is required to evaluate the full ramifications of managed care for psychiatric populations, studies suggest that some groups face adverse outcomes under this system. For example, Rogers and colleagues[41] found that, on average, patients with depression who were treated by psychiatrists under prepaid treatment plans acquired new limitations in their physical or day-to-day functioning during a 2-year period, whereas those treated in the traditional fee-for-service setting did not.

Autonomy and Neutrality

Early in this century, Sigmund Freud recommended that psychoanalysts adhere to a position of *neutrality* with their patients by refraining from the temptation to take sides in the patients' internal conflicts or life problems.[42, 43] This advice has relevance for all psychiatric treatment, insofar as it espouses the idea that practitioners should maintain profound respect for their patients' autonomy and individuality. This is a fundamental therapeutic stance that fosters independence, growth, and self-esteem. It reinforces the idea that the clinician believes the patient to be the owner of his or her body, life, and problems. The patient receives the following message:

> The doctor tries to help by assisting me to learn about myself, not by trying to take control of me.

Indicated ways to encourage autonomy include encouraging informed consent by outlining the potential benefits, risks, and alternatives for a proposed treatment approach; explaining the rationale for the treatment; and fostering the patient's participation in the treatment process. Paradoxically, acutely suicidal patients often require the psychiatrist to assume temporary responsibility for their safety. In most instances this serves to augment the patient's sense of autonomy through a coherent modeling process,[44] because true independence is impossible without self-governance.

Clinical actions that may interfere with the patient's autonomy include giving advice regarding nonurgent major life decisions, attempting to exert undue influence on issues unrelated to the patient's health, being reluctant to allow patients to terminate treatment, seeking gratification by

exerting power over patients, and using power over patients as a form of retaliation.

Coherent and Noncollusive Compensation

Although there are tremendous rewards to be obtained from working in an interesting and creative profession, it is better to derive them from one's collective professional endeavors than from one case. With a specific patient, monetary compensation is the only gratification psychiatrists should realistically expect.[27] When compensation is direct, there should be a set fee, and the patient should be responsible for the time. When compensation is indirect or salaried, the psychiatrist must avoid colluding either with the patient against the party paying for the treatment or with the third party against the patient (see the previous section on avoiding dual relationships). Whatever method is being used to pay for mental health treatment, a coherent and noncollusive arrangement imparts the message to the patient:

> The doctor has needs of her or his own, but they are limited to a salary or fee. Aside from financial obligations, I don't have to please, gratify, or nurture my doctor.

The practice of charging for missed appointments under the traditional fee-for-service paradigm is often misunderstood by patients, because their experience with physicians in other branches of medicine has usually been that they were charged on a fee-for-procedure, rather than fee-for-time, basis. Charging for missed appointments is justifiable from an ethical standpoint as long as the rationale is clearly explained to the patient at the beginning of treatment and the patient agrees to it. In addition, no attempt should be made to hide the fact of billing for missed appointments from third-party payers. Some states have an absolute prohibition against billing for missed appointments under Medicaid.[4(p169)] Within certain guidelines, and as of the date of this writing, it is permissible to bill the patient (but not Medicare) for missed appointments under the Medicare program.[4(pp169–170)] Readers are cautioned that regulations regarding Medicaid and Medicare are subject to periodic legislative revisions and may vary according to jurisdiction.

Generally risky compensation arrangements include working for a treatment organization that one perceives to be financially exploitative, accepting small gifts from patients, bartering goods or services in return for treatment, referring patients for treatments or procedures in which one has a proprietary financial interest, and neglecting the patient's failure to adhere to the original agreement regarding payment of fees. Certain practices are absolutely contraindicated and likely to be destructive, including fraudulent billing, accepting expensive gifts, fee splitting, colluding with the patient or third party, and using financial insider information.

Confidentiality

It is essential that psychiatrists treat their patients' communications as privileged. This means that patients alone retain the right to reveal information about themselves. Psychiatrists should caution their patients about the potential limitations to confidentiality and be prepared to explore the consequences of these exceptions. For example, if a patient is raising his or her mental health as an issue in litigation, some or all communications to a psychiatrist could be legally discoverable. Coherent boundaries with regard to confidentiality send the message to the patient:

> My thoughts and feelings belong to me. The doctor does not treat them as if they belong to him or her.

Indicated means of preserving confidentiality include obtaining proper authorization from patients before releasing information, explaining the need for confidentiality with parents of children and adolescents, and involving all participants in family and group psychotherapy in agreements about confidentiality. Problematical activities that may endanger confidentiality include stray communications with concerned relatives of patients in individual psychotherapy, discussion of privileged information with the psychiatrist's own family members, releasing information about deceased patients, and failing to disguise case presentations properly.

Anonymity

Many psychiatrists associate the principle of relative anonymity with Freud's advice to psychoanalysts[42]:

> The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him.

Freud argued that it was dangerous for psychoanalysts to expose their own mental problems or intimate life details in a spurious attempt to place themselves on an "equal footing" with patients.[42(pp117–118)] The merit of this recommendation extends beyond its origin in psychoanalytic technique to a fundamental boundary issue applicable to all forms of psychiatric treatment. It serves as a reminder to both patient and clinician of the professional purpose of the relationship. Avoiding unnecessary personal disclosure to patients protects both patient and practitioner from a reversal of roles—one of the critical themes recurring in boundary violations in general.[25] Many patients experience excessive self-disclosure by the psychiatrist as seductive, and it has frequently been observed to be a precursor to subsequent sexual involvement.[45(p403)] By maintaining a policy of relative anonymity, the patient receives the following message about the treatment:

> This a place where I can bring my issues. The doctor doesn't burden me with his or her problems.

Certain forms of self-disclosure are indicated in the course of work with psychiatric patients, including apprising patients of the clinician's qualifications and treatment methods as part of informed consent, discussing reality factors related to the psychiatrist's health status or intentions regarding retirement that would affect the patient's treatment decisions, and using "reality checks" to help patients contain disturbed and frightening fantasies.

Abstinence

Abstinence means that psychiatrists should discourage direct forms of pleasure such as touching or sexuality in the course of their interactions with patients. For patients, actual gratification is best confined to realistic goals for recovery and emotional growth. Psychiatrists should limit themselves

to the pleasure of getting paid for a job well done and the opportunity to participate in an interesting and creative profession. Although steadfast application of this boundary can be quite frustrating for both psychiatrist and patient, it pays excellent dividends in the long run by encouraging autonomy and a more mature way of dealing with impulses. The rule of abstinence as a therapeutic boundary has a function analogous to that of the incest taboo as a social organizer. In all known human cultures, the incest taboo has survival value because during childhood development it serves to strengthen the sense of individuality and personal boundaries so necessary for growth, independence, and social responsibility.[46]

From a practical standpoint, psychiatrists can strengthen their patients' boundaries in this regard by resisting such behaviors as physical touching, accepting gifts, socialization outside treatment, and sexual involvement. The patient receives the following messages from a clinician who is able to adhere to this principle:

> The doctor is more interested in my health than her or his own gratification and doesn't try to take possession of me. I am learning that I can have wishes that needn't result in action.

There are occasions when psychiatrists are obligated to employ physical procedures such as taking blood pressures, checking for extrapyramidal symptoms, restraining dangerous patients, or administering electroconvulsive therapy. Indeed, clinical touching of patients is considered an integral part of the physician-patient relationship because of its important role in physical examination and therapeutic procedures. Even though psychiatrists are physicians, they are obligated to use much more restraint in this regard than is expected of colleagues in other branches of medicine. It is probably too invasive for the same physician on a protracted basis to intrude simultaneously into the patient's psychological and physical spaces.

Other risky forms of gratification include embracing or kissing patients, eating and drinking with patients, socializing with patients outside the therapy setting, and failing to determine the meaning of recurrent or obsessive sexual fantasies about a patient. Engaging in sexual behavior with current or former patients is contraindicated because it is almost invariably destructive, even though the damage may not be manifest immediately. Although the issue of sexual relationships with former patients continues to stir debate among clinicians,[47, 48] the fact remains that a large portion of our society, including legislators, judges, juries, and licensing boards, view such behavior as highly unprofessional and destructive. Gabbard and Pope[49] emphasized that clinician defendants have frequently raised the posttermination argument in malpractice cases but have never prevailed with this approach.

Self-respect and Self-protection

It is essential that psychiatrists protect themselves from being exploited by patients. This principle is necessary to protect clinicians and patients alike. Many patients seeking treatment have endured abusive relationships in which being victimized became the price for maintaining human connectedness. For such patients, efforts to exploit the psychiatrist may represent an action-question that inquires:

> Must one of us be injured in order for us to have a close relationship?

By setting a proper role model for self-respect and self-caretaking, the psychiatrist imparts the following message to the patient:

> Relationships need not be structured on the basis that one or both parties must be exploited. If I as the doctor allow you to hurt me, I am setting a poor role model.

Psychiatrists should attempt to discuss the meaning of any exploitative behavior on the patient's part as soon as possible. With unstable or impulsive patients who are prone to acting out, confrontation should be timed to maximize safety. For example, it would be more prudent to interpret the manipulative aspects of a patient's suicidal behavior after the patient is admitted to a hospital. If a patient makes a sudden physical overture such as attempting a sexually provocative embrace, it must be dealt with the same urgency as a physical assault. The psychiatrist should inform the patient that such behavior is inconsistent with coherent treatment.[4(pp228–231)] It is generally risky to allow repeated exceptions such as last-minute prolongation of sessions, repeated lateness in paying fees, repeated intrusions into the psychiatrist's personal space in the form of late night phone calls, or taking items from the office.

Certain psychiatrists find themselves avoiding confrontation with an exploitative patient out of fear of the latter's narcissistic rage. This is an indication of an escalating situation that may lead to further boundary violations by either the patient or the psychiatrist. A useful explanation of this behavior is provided in Gabbard's[51] description of a subgroup of clinicians who become sexually involved with patients as part of a self-defeating pattern of behavior he termed "masochistic surrender." These practitioners are unable to defend against being tormented by certain highly demanding patients. They succumb to the patient's importunings, sometimes while in a dissociated state, even though they may know that their behavior is wrong. Gabbard thought that the aberrant behavior of these clinicians is rooted in an impaired ability to cope with their own aggressive feelings, resulting in their feeling that it would be sadistic to set limits on the patient.

Summary

The ethical and boundary issues discussed in this chapter were designed to stimulate a better understanding of an extremely thorny topic rather than to provide an exhaustive compendium. Table 4–7 summarizes selected indicators of potential boundary violations, along with remedial responses clinicians might employ to deal with these situations.

The difficulties psychiatrists may encounter in keeping boundaries derive from many sources. In the past, professional training programs have not addressed this issue systematically. It behooves psychiatrists to determine whether they have suffered deficiencies in training or adverse role modeling during the course of their professional development and whether their own emotional problems significantly interfere with maintaining coherent professional boundaries. A burgeoning literature regarding the

Table 4–7 Indicators of Potential Boundary Violations with Suggested Remedial Responses

Indicator	Suggested Remedial Response for Clinician
Clinician is frequently tardy starting sessions.	Avoid criticizing the patient for complaining about lateness. Reexamine reasons for tardiness in light of the patient's need for a stable treatment frame.
Clinician changes the treatment paradigm in midstream, for example, switching from individual therapy with Mr. A to couples therapy with Mr. A and Mrs. A.	Avoid dual relationships that may interfere with primary loyalty to the first patient. If dual relationships cannot be avoided, explain risks to patients according to principle of informed consent.
Clinician frequently advises patients on matters not related to the treatment process.	Consider whether this is a general pattern of need for control in one's nonclinical relationships. If so, consider ways to help the patient to make her or his own decisions.
Clinician often relates to the patient as if he or she were a personal friend.	Listen for signs that the patient feels burdened. Acknowledge the pattern of role reversal and the importance of the clinician's fiduciary obligations to the patient.
Clinician accepts gifts from the patient.	Try to explore the patient's motive for the gift. Consider refusing the gift by explaining that it might interfere with the effectiveness of treatment. Be prepared to work with the patient's and one's own feelings of shame in this regard.
Clinician feels overly resentful about having to keep boundaries because they feel too constraining and spoil the "fun" and creativity of being a therapist.	Remember that therapy is hard work that is often burdensome and frustrating and that boundaries are necessary for the patient's safety.
Clinician seeks contact with the patient outside therapy setting.	Avoid contact, and explain the reason to the patient. In settings where social contact is likely, discuss problems and options with the patient in advance.
Clinician is unable to confront patients who are late paying fees, remove items from the office, repeatedly try to prolong sessions, or torment therapist with insatiable demands.	Listen to the content of the patient's communications and dreams regarding people injuring one another. Explore fear of one's own anger, the patient's anger, or of setting limits.
Clinician often tries to impress patients with personal information about himself or herself.	Refrain from further disclosure and examine one's possible motives. Consider how such activity might relate to sexual feelings for patient or need to control the patient.
Clinician becomes sexually preoccupied with patient—for example, feels a pleasurable sense of excitement or longing when thinking of the patient or anticipating the patient's visit.	Consider that one's sexual feelings may portend the reenactment of an actual or symbolic incestuous scenario from the patient's past. Remember that incestuous behavior or its symbolic equivalent infantilizes the victim. Obtain supervision and/or personal psychotherapy if sexual preoccupations continue unabated.

psychological characteristics of clinicians who have problems in maintaining proper boundaries[4, 14, 27, 45, 51–54] might provide useful guidance in this regard.

Medical and psychiatric ethics are based on an ancient tradition of adherence to the values of trust and commitment to a healing relationship. These values transcend the uncertainty of our current scientific knowledge, because they are based on principles that augment a mature form of relatedness. The ethical psychiatrist follows these principles for the patient's well-being. In turn, this encourages the trust that is necessary for biological, psychodynamic, and behavioral treatments to be successful. By cultivating these values and the principles embodied within them, maintaining professional skills through training and continuing education, obtaining personal psychotherapy, and utilizing supervision and consultation when indicated, the ethical psychiatrist increases the chance that an effective partnership for healing will be forged.

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